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CAROTID QUESTIONNAIRE

PATIENT'S NAME: _____ DATE: _____/_____/_____

REFERRING PHYSICIAN: _____

FAMILY PHYSICIAN: _____

CHIEF COMPLAINT: _____

Are you Right-handed ☐ Left-handed ☐

Have you ever experienced any of the things below?
If "Yes," where appropriate indicate **R**ight or **L**eft by circling and in the last column give dates to the best of your remembrance. Please use the space at the end of this questionnaire or the back if you need additional room to write.

	HAVE YOU EVER EXPERIENCED ANY OF THE THINGS BELOW?	YES	NO	DATES
1	Weakness, paralysis or clumsiness of one or both hands or feet?	**R L**		
2	Numbness or loss of sensation in the face, arms or legs?	**R L**		
3	Difficulty in controlling your feet or making them step where they are supposed to?	**R L**		
4	Staggering and difficulty with your equilibrium or balance?			
5	Loss of memory or not being able to remember things?			
6	Slurring or thickness of speech and difficulty forming words?			
7	Have you ever had changes in your face, such as:			
	Drooping?	**R L**		
	Trouble controlling saliva in the corner of your mouth?	**R L**		
	Eye movements not being correct?	**R L**		
	Numbness on one side of your face?	**R L**		
8	Have you ever had			
	Inability to understand what you were being told?			
	Inability to speak for a few seconds or longer?			
9	Have you ever			
	Passed out or lost consciousness?			
	Nearly passed out but caught yourself before you did?			
	Passed out and hit the floor without warning?			

Patient Name: _____

	HAVE YOU EVER EXPERIENCED ANY OF THE THINGS BELOW?	YES	NO	DATES
10	Have you ever had			
	Dizziness?			
	Dizziness when you stand up or move?			
	Do you ever feel that you are spinning or that the things around you are spinning?			
11	Do you ever have			
	a. Hoarseness?			
	b. Double vision?			
	c. Confusion?			
	d. Hiccups?			
	e. Vomiting?			
	f. Difficulty swallowing?			
12	Have you ever had any of the above symptoms when you exercise one arm?			
	If Yes, which ones?			
13	Have you ever had difficulty with fine movements of your fingers or coordination when doing things such as holding a cup or spoon or trying to write?	**R L**		
14	Have you ever had a change in your hearing?	**R L**		
15	Have you ever had a convulsion or a seizure?			
16	Have you ever experienced vision like someone pulling a curtain over your eye that lasted for a few seconds and then cleared?	**R L**		
17	Have you ever had blindness in one corner or half of your eye on one side or both sides?	**R L**		
18	Do you ever hear your pulse (a swishing sound) in your ear?	**R L**		
	If so, do you notice it when you try to sleep?	**Y N Y N**		
19	Has any physician ever told you that he has heard an abnormal sound in your neck or a bruit?			
	Has anyone ever suggested that you are not getting enough blood flow to your brain or that you have hardening of the arteries to your brain?			
20	Has your eye doctor ever suggested that you have had a stroke in your eye?	**R L**		
	Was it suggested that you see another doctor?			
	Have you had a blood clot in your eyes?	**R L**		

Patient Name: _____

	HAVE YOU EVER EXPERIENCED ANY OF THE THINGS BELOW?	YES	NO	DATES
21	Has any other doctor ever suggested that you may not be getting enough blood flow to your brain?			
22	Are you afraid that you are not getting enough blood flow to your brain?			
23	Have any of your family members or friends suggested that you may not be getting enough blood flow to your brain?			
24	Have any of your family or friends suggested that you have had a problem with your mind or a change in your personality, but you were not aware of a change?			
	Are you afraid that they have suggested that you might have trouble with the blood flow to your brain?			
25	Do you develop dizziness or numbness?			
26	Do you have circulation problems in your arms?	**R L**		
27	Do you have circulation problems in your legs?	**R L**		
28	Do you have circulation problems in your arteries (***not your veins***)?			
29	Do you have heart problems?			
	If Yes, describe:			
30	Do you have cataracts?	**R L**		
31	Do you have a detached retina?	**R L**		
32	Do you have glaucoma?			
	Have you ever had a test for glaucoma			
	Did the doctor give you drops to make your eyes numb?			
33	Have you ever had permanent blindness?	**R L**		
34	Have you ever had a corneal transplant	**R L**		
35	Have you had an eye injury in the last six (6) months?	**R L**		
36	Have you had other eye surgery?			
	If Yes, describe			

Patient Name: _____